## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/11/2015 FORM APPROVED OMB NO. 0938-0391

|  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |   |  | COM   | B) DATE SURVEY<br>COMPLETED  |   |
|--|--|---|--|---|--|---|
|  | 345551   | B. WING   |  |   | C<br>7/ <b>17/2015</b>   |   |
| NAME OF PROVIDER OR SUPPLIER  PRUITTHEALTH-CAROLINA POINT  |  |   | 593  | 5 MOUNT SINAI ROAD  | 017  | 1772010   |
| SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   |  | ID<br>PREFIX<br>TAG   |  |   |  | (X5)<br>COMPLETION<br>DATE  |
| DEPENDENT RES  A resident who is undaily living receives   | IDENTS  nable to carry out activities of the necessary services to   | F 3   | 312  |   |  | 8/8/15  |
| by: Based on observative record/document reprovide the eating a physician for 1 of 2 #5) assessed as detaing assistance.  Resident #5 was as 5/27/2014 with the Vascular Accident with Hypertension, Atria The last Minimum I completed on 6/9/2 requiring extensive was also coded on having short and lowell as being highly plan last reviewed on hydration due to the interventions of the interventions of the interventions of the interventions offered beverages I pathology report daresident presented, dysphagia." Recompression of the interventions of the int | cion, staff interviews, and eview the facility failed to assistance as ordered by the sampled residents (Resident ependent upon the facility for The findings include:  Imitted to the facility on diagnoses of Cerebral with Aphasia, Dysphagia, I fibrillation, and Blindness. Data Set (MDS) Assessment 015 coded the resident as assistance with eating. He the MDS assessment as ng term memory problems as a impaired for vision. The care on 6/9/2015 listed one of his ntial for alteration in nutrition o current disease process."  In the care plan did not state be assisted with eating. One did state that he was to be defore each meal. A speech ted 10/13/2014 stated that the "with mild oropharyngeal mendations were made at   |   |  | written allegation of compliance. Preparation and submission of this correction does not constitute an admission or agreement by the provide truth of the facts alleged or the correctness of the conclusions set from the statement of deficiencies. The plan of correction is prepared and submitted solely because of require under state and federal law.  Corrective action will be accomplish the resident found to have been affectly the deficient practice:  Resident #5 has been re-evaluated Speech and Occupational therapy a has been admitted to case load. Fare following current physician order what therapy is evaluating and treating.  Corrective Action for Those with Post to be affected.  All residents with orders for assistar with feeding has a potential to be affected.   | plan of vider of orth he ments led for ected by and cility is lile tential   |   |
|  |  | NATI IRE  |  | TITLE   |  | (X6) DATE   |
|  | SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE  483.25(a)(3) ADL CO DEPENDENT RES  A resident who is undaily living receives maintain good nutri and oral hygiene.  This REQUIREMENt by: Based on observative record/document reprovide the eating a physician for 1 of 2 #5) assessed as de eating assistance.  Resident #5 was ac 5/27/2014 with the extra two services of the last Minimum I completed on 6/9/2 requiring extensive was also coded on having short and lowell as being highly plan last reviewed con the resident was to of the interventions of the inte | REALTH-CAROLINA POINT  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS  A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.  This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and record/document review the facility failed to provide the eating assistance as ordered by the physician for 1 of 2 sampled residents (Resident #5) assessed as dependent upon the facility for eating assistance. The findings include:  Resident #5 was admitted to the facility on 5/27/2014 with the diagnoses of Cerebral Vascular Accident with Aphasia, Dysphagia, Hypertension, Atrial fibrillation, and Blindness. The last Minimum Data Set (MDS) Assessment completed on 6/9/2015 coded the resident as requiring extensive assistance with eating. He was also coded on the MDS assessment as having short and long term memory problems as well as being highly impaired for vision. The care plan last reviewed on 6/9/2015 listed one of his problems as, "Potential for alteration in nutrition and hydration due to current disease process." The interventions on the care plan did not state the resident was to be assisted with eating. One of the interventions did state that he was to be offered beverages before each meal. A speech pathology report dated 10/13/2014 stated that the resident presented, "with mild oropharyngeal dysphagia." Recommendations were made at that time by the speech pathologist. Physician's | A BUILD ROWNER OF CORRECTION  345551  B. WING  REALTH-CAROLINA POINT  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS  A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.  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Physician's | ROVIDER OR SUPPLIER  ### IBALTH-CAROLINA POINT    SUMMARY STATEMENT OF DEFICIENCIES (READ DEFICIENCY) STATE AND F CORRECTION SINAI ROAD DURHAM, NC 27705    SUMMARY STATEMENT OF DEFICIENCIES (READ DEFICIENCY) STATE AND F CORRECTION SHOULD CROSS-REFERENCED TO THE APPROPR TAG TO SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)    483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS   A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.    This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and record/document review the facility failed to provide the eating assistance as ordered by the physician for 1 of 2 sampled residents (Resident #5) assessed as dependent upon the facility for eating assistance. 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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

07/31/2015

**Electronically Signed** 

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION A. BUILDING |  |   | (X3) DATE SURVEY<br>COMPLETED |  |
|---|--|---|--|--|---|-------------------------------|--|
|   |  | 345551  | B. WING _                              |  |   | C<br><b>17/2015</b>           |  |
| NAME OF F   | PROVIDER OR SUPPLIER   |   |  | STREET ADDRESS, CITY, STATE  |   | 1172010                       |  |
|   |  |   |  | 5935 MOUNT SINAI ROAD  |   |                               |  |
| PRUITTH   | IEALTH-CAROLINA P  | POINT   |  | <b>DURHAM, NC 27705</b>  |   |                               |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC)   | NTEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                    | PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE  | ACTION SHOULD BE<br>TO THE APPROPRIATE  | (X5)<br>COMPLETION<br>DATE    |  |
| F 312   | Continued From page 1  |   | F 3                                    | 12   |   |                               |  |
| F 312   | orders for July 2019 consistency with gr double portion entremeals, alternate liq seated up right for mouth is clear before the clear before leaving 12:45 PM the Direction the room and a help. The DON sat the food into his own DON remained with slow down as he fee | 5 stated, "Diet: Mechanical soft ound meats, thin liquids, ee, resident should be fed all uids and solids, should be all meals, make sure patients re leaving patient."  made of the lunch meal for 7/2015 beginning at 12:30 PM. titing in his wheelchair with a cont of him. At 12:35 PM a rought a lunch tray to Resident ray in front of him. The nursing eresident to get a mouthful of the room to assist with passing At 12:40 PM the nursing pped in the resident's room sident with another mouthful of the room again. The make sure patient's mouth is a patient was not followed. At cor of Nursing (DON) came asked the resident as he lifted on mouth. At 12:52 PM the in the resident and told him to ded himself. When the resident | F3                                     | Manager and the Unit audit 100% of the med orders requiring assist C NA care Guides will Manager and Unit Coowith current orders. The updates of care plans by 8/7/15  Measures put into place changes made to ensure practice will not occur:  The following systemic implemented to prevent The Clinical Competer began in-service on 7/staff on feeding assist training will emphasize using the C NA Care Construct staff as to the Residents with a declinative transfer of the treatment and any instantive instructions from the Twill be reviewed by the | dical records for twith feeding. The be updated by Unit ordinator if needed ne audit and will be completed are that the deficient or changes will be not re-occurrence. Incy Coordinator (21/15 the nursing ance, and this e the importance of Guides that will resident; s needs.  The rapy department of Unit Manager and |                               |  |
|   | spoonful of green be<br>fish. She then offer<br>PM the resident wa<br>DON. At 1:00 PM the<br>food or liquids from  | mself, the DON offered him a peans and then a spoonful of ed pie to the resident. At 12:55 as offered a drink of fluid by the ne resident refused any more the DON. The physician's quids and solids was not  |  | the Unit coordinator to instructions are added guide and the Resider Unit Manger and the Ureview all orders requifeeding to ensure all o C NA Care Guides and  | I to the C NA Care It Care plan. The Jnit Coordinator will ring assistance with orders are added to   |                               |  |
|   | At 1:05 PM on 7/17 assigned to the res   | 7/2015 the nursing assistant ident was interviewed. She at #5 needed help drinking  |  | Facility plans to monitor to make sure that solution The facility must develop ensuring that correction  | itions are sustained.<br>lop a plan for   |                               |  |

Facility ID: 20090049

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|   |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION A. BUILDING   |  | COM   | (X3) DATE SURVEY<br>COMPLETED |  |
|---|--|--|--|--|---|-------------------------------|--|
|   |  | 345551   | B. WING _  |  |   | C<br>17/2015                  |  |
| NAME OF PROVIDER OR SUPPLIER  PRUITTHEALTH-CAROLINA POINT |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE  5935 MOUNT SINAI ROAD  DURHAM, NC 27705 |  |   |                               |  |
| (X4) ID<br>PREFIX<br>TAG                                  | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORF  | SHOULD BE   | (X5)<br>COMPLETION<br>DATE    |  |
| F 312   | fluids and he needed to eat. She stated, he feeds himself." at 1:20 PM that Res She also stated that assist him because hand.  On 7/17/2015 at 3:3 stated that the resid speech therapy for physician's orders for the stated to the state of t | ge 2 ed someone to encourage him "We feed him and sometimes The DON stated on 7/17/2015 sident #5 ate 25% of the meal. It she went into the room to he was picking up pie with his  30 PM the DON additionally dent would get a referral to evaluation. She said the for Resident #5 would either be dated with his current needs. | F 3 <sup>-</sup>   | sustained:  The unit manager, Director of Services and staff nurses will residents requiring assistant for breakfast, Lunch and dintrodocument compliance weekly weeks, then monthly for 2 moncerns will be corrected in and the staff will be re-educatime. The results of observating discussed in QA monthly for then re-evaluated for continuity compliance. | Il observe<br>te with meals<br>ner, to<br>y for four<br>onths. All<br>nmediately<br>ated at that<br>tions will be<br>3 months and |                               |  |